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IN THE
Supreme Court of the United States
OCTOBER TERM, 1993

THE METHODIST HOSPITAL, *et al.*,
Petitioners,

v.

DONNA E. SHALALA, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Respondent.

Petition for a Writ of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether the adjustments mandated under 42 U.S.C. § 1395ww(b)(4)(A) are applicable to the calculation of the hospital-specific portion of a hospital's Medicare reimbursement under 42 U.S.C. § 1395ww(d) during the four year transition period under Medicare's prospective payment system.

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PETITION FOR A WRIT OF CERTIORARI

The Methodist Hospital, St. Vincent's Hospital and Medical Center of New York and General Care Corporation d/b/a West Side Hospital ("Petitioners")[1] respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the District of Columbia Circuit in this case.

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[1] *Rule 29.1 Statement*: Parties to this action include: The Methodist Hospital, a non-profit corporation, St. Vincent's Hospital and Medical Center of New York, a non-profit corporation and General Care Corporation d/b/a West Side Hospital, a wholly-owned subsidiary of Columbia/HCA Healthcare Corporation, a publicly traded corporation.

OPINIONS BELOW

The orders and judgment of the Court of Appeals (Appendix 1a)[2] are unreported. The opinion and orders of the District Court (App. 14a, 16a, 24a, 26a) are unreported. The decisions of the Provider Reimbursement Review Board ("PRRB") (App. 28a, 43a, 58a), are unreported.

JURISDICTION

The judgment of the Court of Appeals was entered on September 16, 1993. (App. 1a.) The order of the Court of Appeals denying the Petition for Rehearing was entered on November 16, 1993. (App. 65a.) This Court's order granting Petitioners' Application for Extension of Time Within Which to File a Petition for Writ of Certiorari was entered on February 3, 1994, and granted Petitioners an extension to and including March 16, 1994. (App. 66a.) The jurisdiction of the Court is invoked under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS

The following statutes and regulations are set forth in the Appendix to the Petition:

42 U.S.C. § 1395ww(a)
42 U.S.C. § 1395ww(b)
42 U.S.C. § 1395ww(d)
42 C.F.R. § 412.71
42 C.F.R. § 412.72

STATEMENT OF THE CASE

A. Introduction.

This case involves appeals brought by several acute care hospitals, Petitioners, challenging Medicare reimbursement determinations made by fiscal intermediaries and adopted by the PRRB. The substantive issue raised is whether the adjustments mandated under 42 U.S.C. § 1395ww(b)(4)(A) (hereinafter referred to as "subparagraph (b)(4)(A)") are applicable to the calculation of the hospital-specific portion of a hospital's Medicare

[2] Pages in the Appendix are cited as "App."

reimbursement under 42 U.S.C. § 1395ww(d)(1)(A) (hereinafter referred to as "subparagraph (d)(1)(A)") during the four year transition period under Medicare's prospective payment system. The inconsistent resolution of this issue by three courts of appeals, including the court below, raises questions of statutory construction (whether Congress' clear intent can be inferred from statutory silence) and judicial deference to agency action (whether deference should be accorded to an agency's litigation position or to the agency's position developed by key officials of the Medicare program over a period of years). The Secretary's litigation position on this issue is that, because subparagraph (b)(4)(A) is not specifically referenced in subparagraph (d)(1)(A), Congress did not intend such applicability.

Petitioners acknowledge that this issue was recently presented to this Court in the Petition For a Writ of Certiorari filed on September 16, 1993 in *Episcopal Hospital, et al. v. Shalala*, 994 F.2d 879 (D.C. Cir. 1993), *cert. denied*, No. 93-429, 62 U.S.L.W 3471 (January 14, 1994) ("*Episcopal*").[3] However, as noted by the Solicitor General in the Brief for the Respondent in Opposition at 15-16, in *Episcopal*, a favorable resolution of the issue presented to this Court would not have affected the ultimate outcome of that dispute. Even if this Court found that subparagraph (b)(4)(A) is applicable to the calculation of the hospital-specific rate under subparagraph (d)(1)(A),[4] the petitioners in *Episcopal* would not have prevailed. In that case, the court of appeals also found that the petitioners failed to satisfy the criteria of subparagraph (b)(4)(A),[5] and that finding was not contested in the *Episcopal* petition.

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[3] The court of appeals in these consolidated cases overturned the decisions of the district court without opinion, relying on its recent opinion in *Episcopal*. (App. 3a.)

[4] Unless noted otherwise, all references in this Petition to statutory provisions are to Title 42 of the United States Code.

[5] In *Episcopal*, the hospitals argued that, because the coverage of inpatient hospital days differed between the prior system and

Such is not the case here. Unlike *Episcopal*, Petitioners in these consolidated cases do not rely on any novel theory of what constitutes an "extraordinary circumstance" under subparagraph (b)(4)(A). Instead, Petitioners' requests satisfied accepted standards for the requested adjustment, that is, each Petitioner either added new services or facilities. In any event, whether Petitioners qualify for an adjustment under subparagraph (b)(4)(A) must be decided by the administrative tribunal below, the PRRB, as noted by the district court's orders of remand issued in these cases.

Furthermore, as explained below, this case raises significant issues that are timely for review by this Court. First, there is a split among the Courts of Appeals for the Ninth, Third and District of Columbia Circuits on the substantive issue raised herein. Those courts' opinions are so diametrically opposed in the application of differing legal theories, that they have and will continue to create confusion in the other circuits, which will require resolution by this Court.[6]

Second, this case raises important questions regarding judicial deference to agency action under *Chevron U.S.A., Inc. v. Natural Resources Defense Council Inc.*, 467 U.S.

PPS, an adjustment under subparagraph (b)(4)(A) was required to establish comparability between the base year used to calculate the HSP and the years in which the HSP would be used to calculate PPS payments. Both the district court and the court of appeals in *Episcopal* agreed that such a concern was not the kind of adjustment envisioned under subparagraph (b)(4)(A). In fact, the court of appeals noted that such an issue called into question the validity of certain Medicare coverage regulations which had not been challenged in that case.

[6] In fact, in *Hillsborough County Hosp. Auth. v. Shalala*, Medicare and Medicaid (CCH) ¶ 41,979 (M.D. Fla. Nov. 9, 1993), *appeal docketed*, No. 94-2050 (11th Cir. Jan. 7, 1994) one hundred fourteen Florida hospitals were denied relief on this issue in reliance upon the decisions of the Third Circuit in *Sacred Heart Medical Center v. Sullivan*, 958 F.2d 537 (3rd Cir. 1992) ("*Sacred Heart*") and the D.C. Circuit in *Episcopal*.

837 (1984) ("*Chevron*") and *Good Samaritan Hospital v. Shalala*, —— U.S. ——, 113 S. Ct. 2151 (1993) ("*Good Samaritan*"). This case provides the Court with a timely opportunity to clarify the application of an agency's "mistake" defense to a limited deference standard embraced by the Court in *Good Samaritan*, 113 S. Ct. at 2160-61.

Third, the *Episcopal* court reached its substantive conclusion based on an incomplete administrative record. However, Petitioners fully litigated the substantive issue presented here at the district court. Petitioners prevailed in the district court and presented a complete record to the court of appeals on that issue. However, because *Episcopal* was scheduled before this case for briefing and argument in the court of appeals (even though this was the lower numbered case), the court of appeals was denied the necessary benefit of a complete administrative record which resulted in a flawed decision.

Petitioners firmly believe that, if the Court has the opportunity to consider the administrative record available in this case, the decisions of the United States Courts of Appeals for the Third Circuit and the District of Columbia Circuit will be reversed.

B. The Underlying Case.

In 1983, Congress created the Prospective Payment System ("PPS") to replace Medicare's reasonable cost based system used to determine payment for inpatient hospital services. Under PPS, hospitals are reimbursed for inpatient costs on the basis of prospectively determined federal rates, rather than actual operating costs. 42 U.S.C. §§ 1395ww(d)(1) and (4).

"Congress recognized that implementation of the new PPS threatened severe financial dislocations in the health care delivery system." *Georgetown University Hospital v. Bowen*, 862 F.2d 323, 324 (D.C. Cir. 1988). Accordingly, Congress provided a four year phase-in or transi-

tion period for PPS for the express purpose of "minimize-[ing] disruption that might otherwise occur because of sudden changes in reimbursement levels." S.Rep.No. 23, 98th Cong., 1st Sess. 53, *reprinted in* 1983 U.S. Code Cong. & Admin. News 143, 193. (App. 100a.)

The method chosen by Congress to ease the impact of a hospital's entry into PPS was the use of a "blended" Medicare payment rate, consisting of a decreasing hospital-specific portion ("HSP"), which reflects each hospital's adjusted and estimated cost of providing patient care in a base year, and an increasing federal portion, which is based on a blend of regional and national average costs (the "DRG" rate). 42 U.S.C. § 1395ww(d)(1)(A). This appeal concerns the proper method for calculating the HSP during the PPS transition period.

1. *The Procedural History.*

Petitioners are three acute-care hospitals that provide inpatient care to Medicare beneficiaries. Two of Petitioners underwent major construction and renovation projects that began before Congress created PPS and were completed after the hospitals' base year, but before they began receiving payments under PPS. These projects resulted in significant increases in each hospital's operating costs which were not reflected in the hospitals' base year costs.

The third Petitioner began construction of a new emergency room service before Congress implemented PPS and commenced operating that new service subsequent to the close of its base year, but before it began receiving payments under PPS. Thus, this Petitioner incurred no emergency room costs during its base year.

As explained in more detail below, the hospital-specific portion of a provider's reimbursement during the four year PPS transition period is based on its TEFRA[7] target

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[7] "TEFRA" is the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, as codified at 42 U.S.C. § 1395ww(b),

amount which is estimated from the hospital's base year costs. Because the costs associated with Petitioners' construction projects and emergency room services were not incurred during their base years, the initial computation of the HSP portion of their PPS reimbursement rate failed to recognize any of these costs.

Each hospital requested an adjustment to the HSP portion of its PPS rate in accordance with 42 U.S.C. § 1395ww(b)(4)(A), referred to as "TEFRA Adjustments," and within the process outlined in 42 C.F.R. § 412.71(c), before it became subject to PPS. The TEFRA Adjustments provision directs the Secretary to revise the target amount calculated for a hospital when an event beyond the hospital's control or extraordinary circumstances cause a distortion in that reimbursement rate. Petitioners' requests were denied by their fiscal intermediaries, not because the requested adjustments fell outside of the definition of a TEFRA Adjustment, but because of uncertainty as to whether such adjustments were available for hospitals in PPS.

Pursuant to 42 U.S.C. § 1395oo, each hospital appealed to the PRRB, challenged the intermediaries' denials of the requests for a TEFRA Adjustment. The PRRB upheld the intermediaries' determinations in each appeal. (App. 41a, 56a, 63a.)

Petitioners separately initiated suits in the United States District Court for the District of Columbia. After extensive briefing by all parties, the district court ruled in favor of each Petitioner, finding that subparagraph (b)(4)(A) is applicable when calculating Petitioners' HSPs if they satisfy the criteria therein. The district court remanded these cases to the PRRB to determine whether, under the particular facts of each case, Petitioners were

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which established limitations on the prior cost based reimbursement system by establishing a target amount from a base year, which is subject to the revision under subparagraph (b)(4)(A), and limiting annual increases in excess of the target amount.

entitled to TEFRA Adjustments. The Secretary appealed the district court's decisions. Petitioners cross-appealed on the issue of remand, but withdrew those cross-appeals. These cases were consolidated at the court of appeals.

Subsequent to the filing of the appeal in *Methodist*, the hospitals in *Episcopal* filed their appeal from the district court's decision. They did not list *Methodist* as a related case, presumably because in *Episcopal* the issue of the applicability of subparagraph (b)(4)(A) to the HSP calculation was assumed by the district court in favor of the hospitals without the benefit of briefing by either party. When the Secretary filed docketing materials in *Episcopal*, she did not list *Methodist* as a related case.

Surprisingly, even though *Methodist* was the lower numbered case at the court of appeals, *Episcopal* was scheduled first for briefing and argument. At that period in time, counsel in *Methodist* were unaware of the *Episcopal* appeal and its relatedness to *Methodist*.

Before briefing commenced in *Episcopal*, *Methodist* counsel became aware of that case. Concerned that the issue of the applicability of the TEFRA Adjustments to PPS would become an issue in *Episcopal*, *Methodist* counsel began investigating the state of the record in *Episcopal* on that issue. After it became evident that such a record was nonexistent, counsel began efforts to bring a complete record of that issue to the *Episcopal* court's attention

Over a period of six weeks, Petitioners in *Methodist* filed in *Episcopal* a motion to consolidate, a motion for permission to file an *amici* brief and a motion to reconsider permission to file *amici* brief with brief attached. Each of those motons was denied.

On June 18, 1993, the court of appeals issued an opinion in *Episcopal* which reversed the district court's finding in that case on the applicability of the TEFRA Adjustments to the calculation of the HSP in favor of the Secretary and also affirmed the district court's decision that, in any case, the requested adjustment was not per-

mitted as a TEFRA Adjustment. Under the decisional law of the District of Columbia Circuit, the *Episcopal* decision bound the panel which was assigned to Petitioners' case absent *en banc* consideration. *See Brewster v. Commissioner of Internal Revenue Service*, 607 F.2d 1369, 1373 (D.C. Cir. 1979). Petitioners requested that their case be converted into a hearing *en banc*, in light of the fact that their panel of the court of appeals was bound by *Episcopal*. The request was denied. The court of appeals canceled oral argument and issued the one page judgment under appeal here, adopting the *Episcopal* decision and reversing the district court. A petition for rehearing *en banc* was also denied.

Due to this procedural history, this Petition will focus on the decision rendered in *Episcopal*. Petitioners respectfully suggest that the errors in *Episcopal* are based on an incomplete administrative record and incomplete briefing,[8] which could have been avoided if *any* of Petitioners' procedural motions had been granted.

2. *The Applicability of 42 U.S.C. § 1395ww(b)(4)(A) When Determining the HSP During the PPS Transition Period.*

Petitioners contend they are entitled to TEFRA Adjustments under subparagraph (b)(4)(A), resulting in a revised target amount and resulting HSP, because of extraordinary circumstances occurring during and/or after their base year, but before their first PPS year and before the HSP was finally set. This contention is supported by the express language in the statute, the legislative history and the agency's official actions in similar circumstances. It is only in the context of litigation that the Secretary has adopted a "newer" official interpretation based on an unsupported "mistake" defense, which is not countenanced under the principles stated by this Court in *Good Samaritan*.

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[8] For example, none of the materials contained in App. 67a-74a, 119a-129a were contained in the *Episcopal* record.

a. *The Statute.*

As explained above, during the PPS transition period, the payment for inpatient hospital services is determined by blending the federal DRG rate and the HSP. 42 U.S.C. § 1395ww(d)(1)(A). The HSP is defined as a specified percentage of a hospital's "target amount" for the cost reporting period. *Id.*

The term "target amount" is defined in 42 U.S.C. § 1395ww(b)(3)(A) (hereinafter referred to as "subparagraph (b)(3)(A)") and refers to the reimbursement system that preceded PPS to limit hospital cost increases after a base year. *See* note 7, *supra*, at 6-7. Under TEFRA, Congress requires adjustments to the target amount (called "TEFRA Adjustments"), resulting in a different target amount, when events beyond a hospital's control or extraordinary circumstances cause a lack of comparability between the services and costs in the base year and those in the year to which the target amount limit is applied. 42 U.S.C. § 1395ww(b)(4)(A).

Thus, Petitioners maintain that the target amount defined in subparagraph (b)(3)(A) requires "consideration" of the mandatory adjustments under subparagraph (b)(4)(A), which states:

> The Secretary shall provide for an . . . adjustment to, the method *under this subsection* [1395ww(b)] for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, creates a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured).

(emphasis added.) Subparagraph (b)(4)(A) refers to the method for determining the target amount "under this subsection" (*i.e.*, subsection 1395ww(b)), which obviously includes subparagraph (b)(*3*)(A).

The interpretive conclusion is straightforward and logical. The PPS statute, subparagraph (d)(1)(A), ex-

pressly incorporates by direct reference the TEFRA target amount determined under subparagraph (b)(*3*)(A). The Secretary's calculation of the TEFRA target amount includes, where appropriate, the adjustments mandated by subparagraph (b)(*4*)(A).

Additionally, while the definition of the HSP in subparagraph (d)(1)(A) expressly states that the PPS target amount is to be determined under subparagraph (b)(3)(A), it also expressly states that the HSP is to be calculated "without the application of subsection (a) of this section [section 1395ww(a)]. . . ." Thus, Congress clearly intended the exclusion of one provision, but the *Episcopal* and *Methodist* courts inferred the exclusion of subparagraph (b)(4)(A) as well.

b. *Legislative History.*

The process of reforming Medicare's former cost reimbursed system of inpatient hospital services began in the House of Representatives with the introduction of H.R. 1900, 98th Cong., 1st Sess. (1983). (App. 105a.) In that bill, the House defined the hospital-specific portion of the PPS rate under subparagraph (d)(1)(A) to be the "lesser of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A)), or the limitation established under subparagraph (a) (determined without regard to paragraph (2) thereof) for the period . . . . ." H.R. 1900, 98th Cong., 1st Sess. (1983) at 171 line 22-172 line 2 (App. 103a); *see also* H.Rep. No. 25, 98th Cong., 1st Sess. 136, *reprinted in* 1983 U.S. Code Cong. & Admin. News 219, 355 (App. 99a).[9]

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[9] The Secretary has argued that language in the H.R. 98-25 suggests the House intended to exclude the adjustments under subparagraph (b)(4)(A) from the HSP calculation. However, H.R. 1900 makes clear that it is the adjustments under 42 U.S.C. § 1395ww(a)(2) that were intended to be excluded from the HSP calculation by the House. This point is confirmed by the Conference Report addressed *infra*.

The Conference Report, which accompanied the final passage of these Social Security Act amendments, describes the House Bill as follows:

> Under the House Bill, for the first 2 reporting periods, a calculation of that portion of a hospital's payment which is cost-based [the HSP] would be the lesser of the hospital's payment under the rate of increase limits [subsection 1395ww(b)], without the penalties and bonuses of present law, or the Section 223 limits [subsection 1395ww(a)] without regard to any exemptions, exceptions or adjustments thereto. For the third cost reporting period, the calculation of the cost-based portion would be the hospital's payment under the rate of increase limit only.

H.R. Conf. Rep. No. 47, 98th Cong., 1st Sess. 182, *reprinted in* 1983 U.S. Code Cong. & Admin. News 404, 471-72. (App. 97a.)[10]

Consequently, in that portion of the House version of the bill which concerned 42 U.S.C. § 1395ww(b), the House clearly indicates that it was the hospital's *payment* under subsection 1395ww(b) which would govern the calculation of the HSP. A hospital's payment under this provision would necessarily mean payment of the target amount as adjusted under subparagraph (b)(4)(A). Additionally, the reference to the exclusion of the "exemptions, exceptions or adjustments" only related to the Section 223 limits under subsection 1395ww(a) and not to exemptions, exceptions or adjustments under subparagraph (b)(4)(A). In fact, the only indication in the House Bill that a provision in subsection 1395ww(b) was to be excluded from the HSP calculation was the refer-

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[10] The reference to the rate of increase limits is to 42 U.S.C. § 1395ww(b). The limitation on payments under subsection 1395ww (b), "without the penalties and bonuses of the present law" is to subparagraphs (b)(1)(A) and (B). The reference to the Section 223 limits is to 42 U.S.C. § 1395ww(a). The reference to exemptions, exceptions or adjustments thereto is to 42 U.S.C. § 1395ww (a)(2).

ence to the penalty and bonus payments under subparagraphs (b)(1)(A) and (B). Obviously, if Congress had intended its reference in the PPS legislation to subparagraph (b)(3)(A) to be the only provision in subsection (b) that was applicable to the HSP calculations, it would have been superfluous to refer to the exclusion of subparagraphs (b)(1)(A) and (B) in the committee reports.

The Conference Report states that the Senate adopted the House Bill, except that the Section 223 limits under subsection 1395ww(a) would not apply to the HSP calculation. The Conference Report indicates that the Conference Agreement was to adopt the Senate amendment. The Conference Report also indicates that "since the hospital's specific portion of the rate must be determined in advance of the hospital's first fiscal year under this system, managers expect the Secretary will use the best data available at the time to determine operating costs for purposes of the phase-in period." H.R. Conf. Rep. No. 47, 98th Cong., 1st Sess. 182, *reprinted in* 1983 U.S. Code Cong. & Admin. News at 471-72. (App. 98a.)

Thus, it is clear that Congress knew when it intended to exclude certain provisions from the calculation of the HSP, *i.e.*, subsection 1395ww(a), but did not exclude subparagraph (b)(4)(A). Additionally, the quote from the Conference Report indicates Congress intended some disconnection between actual base year costs and the HSP by indicating that the HSP *should reflect operating costs during the phase-in period.* In spite of this legislative history, which was not even discussed in the opinion, the *Episcopal* court found that Congress clearly intended the exclusion of subparagraph (b)(4)(A) based on a first step *Chevron* analysis.

c. ***The Administrative Actions and Interpretations by the Secretary.***

At the time the Secretary implemented PPS, the Secretary agreed with Petitioners' position here that the TEFRA

Adjustments are applicable to the calculation of the HSP. In the preamble to the final PPS regulations, the Secretary stated:

> We believe that Congress intended to assure, by giving us broad authority under the law to provide for exceptions, exclusions and adjustments, that some hospitals are not advantaged or disadvantaged by unique circumstances in their base year that do not reflect their usual cost of operation per case. This intent is indicated in Section 1886(b)(4)(A) [subparagraph (b)(4)(A)] of the Act.

49 Fed. Reg. 234, 261 (January 3, 1984).

As explained below, within a year of this official statement, in correspondence to Greenville Hospital Systems ("Greenville"), the Administrator of the Health Care Financing Administration ("HCFA"), the chief administrator of the Medicare program, similarly agreed that it was appropriate to adjust Greenville's base year costs based on subparagraph (b)(4)(A), with a resulting prospective adjustment to the hospital-specific portion of each hospital's PPS rate. (App. 119a-123a.) The only issue was whether these TEFRA Adjustments would be applied prospectively or retrospectively to the beginning of PPS. This issue was litigated in federal district court and resulted in a settlement agreement under seal which granted Greenville the retrospective adjustment it had sought.[11]

Almost two years after the HCFA Administrator granted Greenville its prospective TEFRA Adjustments under subparagraph (b)(4)(A), the Secretary issued a proposed rule at 51 Fed. Reg. 8208 (March 10, 1986). (App. 105a.) The proposed regulation would have "clarified" that the Secretary would only (1) recognize a TEFRA Adjustment based on costs that began to be

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[11] Counsel for *Methodist* successfully sought the unsealing of the Greenville settlement agreement as part of its administrative proceedings before the PRRB. (App. 67a-74a.)

incurred in the base year, and (2) recognize such a TEFRA Adjustment prospectively. (App. 112a-115a.) Both principles were specifically rejected by the court in the Greenville litigation and the latter "prospective only" rule was rejected by the District of Columbia Circuit in *Georgetown University Hospital v. Bowen*, 862 F.2d 323 (D.C. Cir. 1988). This proposed clarifying rule was never adopted.

Several months after the proposed regulation was published, in correspondence from HCFA to another provider, HCFA again stated its official policy that a TEFRA Adjustment under subparagraph (b)(4)(A) was applicable to the calculation of the hospital-specific rate. (App. 125a-131a.)

Importantly, the Secretary has never issued a formal policy statement that disavows its prior interpretation or official actions. Rather, it is the Secretary's "litigation position" which the Third Circuit in *Sacred Heart*, and to a limited degree the District of Columbia Circuit in *Episcopal*, accorded deference, where none was due.

REASONS TO GRANT THE PETITION

I. TO SETTLE A CONTROVERSY AMONG THE CIRCUITS OVER A SIGNIFICANT LEGAL ISSUE OF CONTINUING IMPORTANCE.

Issuing a writ of certiorari in this case will provide the Court the timely opportunity to settle a conflict among the circuits on this important issue of statutory construction.

In two separate cases, the Ninth Circuit addressed the application of subparagraph (b)(4)(A) and paragraph (b)(5) to PPS. Based on a first step *Chevron* analysis, the court concluded that both subparagraph (b)(4)(A) and paragraph (b)(5) are applicable to PPS. *See Community Hospital of Chandler v. Sullivan*, 963 F.2d 1206, 1214 n. 4 (9th Cir. 1992) (subparagraph (b)(4)(A) is applicable to the PSP calculation); *Sunshine Health Sys.*

v. Bowen, 809 F.2d 1390, 1398-99 (9th Cir. 1987) (paragraph (b)(5), concerning the selection of a base year, is applicable to PPS). In fact, in *Chandler*, the Secretary acknowledged that the TEFRA Adjustments under subparagraph (b)(4)(A) are available under PPS, but noted that regulations which would clarify the procedures for requesting such adjustments had not been promulgated. 963 F.2d at 1214 n. 4. In addition, the *Chandler* court specifically noted the contrary ruling of the Third Circuit in *Sacred Heart* and rejected that court's analysis in favor of its analysis in *Sunshine*. *Id.*

Both the Third and District of Columbia Circuits found that the plain language of the statute evidenced clear congressional intent that subparagraph (b)(4)(A) is not applicable to the calculation of the HSP under a first step *Chevron* analysis. *Sacred Heart*, 958 F.2d at 545-47; *Episcopal*, 994 F.2d at 883. In addition, the *Sacred Heart* court found that it was appropriate to defer to the Secretary's reasonable interpretation of the statute under a second step *Chevron* analysis. 958 F.2d at 548. The *Episcopal* court also deferred to the Secretary's "reasonable" interpretation, but without any reasoning or guidance as to where such an interpretation might be found and without any reference to the *Sacred Heart* or *Chandler* decisions. 994 F.2d at 883. Thus, not only are the Circuits split on this issue, but their findings and conclusions are inconsistent under a traditional *Chevron* analysis.

Notably, every federal district court to consider this issue, until the recent decision in *Hillsborough County Hospital Authority v. Shalala*, Medicare and Medicaid Guide (CCH) ¶ 41,979 (M.D. Fla. Nov. 9, 1993), *appeal docketed*, No. 94-2050 (11th Cir. Jan. 7, 1994) (which relied on *Sacred Heart* and *Episcopal*), held that the statute, taken in the context of its statutory scheme, clearly indicates Congress' intent to incorporate the TEFRA Adjustments into PPS. In each of those decisions, the courts failed to even reach the second step of a *Chevron* inquiry (*i.e.*, the reasonableness of the agency's

interpretation), finding instead that the intent of the statute was clear.[12]

Finally, the question presented to the Court is of continuing importance. Five additional cases on this issue are currently pending in the United States District Court for the District of Columbia Circuit,[13] as well as the one hundred fourteen hospitals involved in the Eleventh Circuit appeal in *Hillsborough*. In addition to known cases currently pending in court, an unknown number of cases are pending before the PRRB. The PRRB does not track the specific issues raised in individual hospital appeals. Thus, there is no mechanism for determining the number of related cases which still remain at the PRRB level. However, counsel involved in this appeal currently represent a significant number of hospitals with pending PRRB appeals on this issue.

II. TO PREVENT THE PROPAGATION OF MISTAKES.

Issuing a writ of certiorari in this case will give the Court the opportunity to correct fundamental mistakes that have been made by the District of Columbia Circuit

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[12] *Redbud Hospital District v. Heckler*, Medicare and Medicaid Guide (CCH) ¶ 34,085 (N.D. Cal. July 30, 1984), *vacated on other grounds*, 473 U.S. 1308 (1985 J. Rehnquist Circuit Justice); *Greenville Hospital System v. Heckler*, 642 F. Supp. 15 (D.S.C. 1985), *after remand*, Medicare and Medicaid Guide (CCH) ¶ 35,880 (D.S.C. 1986); *Newport Hospital and Clinic, Inc. v. Sullivan*, Medicare and Medicaid Guide (CCH) ¶ 38,844 (D.D.C. Sept. 24, 1990), *Secretary's appeal voluntarily withdrawn* (1991); *The Methodist Hospital v. Sullivan*, Medicare and Medicaid Guide (CCH) ¶ 39,627 (D.D.C. September 20, 1991), *reversed*, No. 91-5402 (D.C. Cir. Sept. 16, 1993) *adopting Episcopal*, 994 F.2d 879 (D.C. Cir. 1993); *Sacred Heart Medical Center v. Sullivan*, 1991 U.S. Dist. Lexis 9535 (E.D. Pa. 1991), *reversed*, 958 F.2d 537 (3rd Cir. 1992).

[13] *Nyack Hospital v. Sullivan*, No. 92-0455; *Okeechobee Hospital v. Sullivan*, No. 92-1323; *HCA Services of Texas v. Sullivan*, No. 92-1324; *Hospital Corporation of Tennessee v. Sullivan*, No. 92-1325; and *General Care Corp. v. Sullivan*, No. 92-1326. In addition, there is one case pending in the Southern District of New York, *Good Samaritan Hospital Regional Medical Center v. Shalala*, No. 92-8726.

in *Episcopal* and the Third Circuit in *Sacred Heart*. These mistakes are now being propagated as courts rely on these decisions, as evidenced by the decisions rendered in this case and in *Hillsborough*.

A. The Third Circuit Opinion in Sacred Heart.

The Third Circuit decision in *Sacred Heart* was based on three significant errors. First, the court deferred to the Secretary's litigation position, rather than the Secretary's official position, which supports Petitioners' argument in this case. Second, the court materially misread a proposed regulation and then applied that misreading as if it were a final regulation. Third, the court made the same errors of statutory construction which were later embraced by the *Episcopal* court.

The first error made by the *Sacred Heart* court is discussed in section III below, which addresses the proper level of deference to be afforded the Secretary's interpretation of a statute. Essentially, the *Sacred Heart* court deferred to the Secretary's interpretation even though that interpretation had admittedly changed over time. The Secretary's purported interpretation in *Sacred Heart* was nothing more than a litigation position. It did not reflect any official position taken by the agency on the issue. Therefore, it should have been afforded no deference.

The second error by the *Sacred Heart* court occurred when it materially misread a proposed regulation which was intended to clarify the Secretary's position on this issue and then applied this misreading as if it were an official change in policy by the agency. 958 F.2d at 548. In 1986 the Secretary issued a *proposed rule* at 51 Fed. Reg. 8208 (March 10, 1986). (App. 105a.) The proposed rulemaking states as its purpose that it:

> [W]ould clarify Medicare's policy regarding changes to the hospital-specific portion of the prospective payment rate for inpatient hospital services. We would clarify that exemptions, exceptions, and ad-

> justments [TEFRA Adjustments] to base year costs permitted under the Medicare cost limits and rate-of-increase ceiling authority will affect the hospital-specific portion of the prospective payment rate.

51 Fed. Reg. 8208 (March 10, 1986). The proposed rulemaking was *not* a change in previous erroneous policy, but was a "clarification" of existing policy.

The March 10, 1986 proposed rule would have "clarified" existing HCFA policy by placing limitations on when costs must begin to be incurred (*i.e.*, not after the base year) and by prohibiting retroactive adjustments. However, HCFA continued to rely on the TEFRA regulations, 42 C.F.R. § 405.460 (*recodified* as § 413.30), *and* 42 U.S.C. § 1395ww(b)(4)(A) as the authority for such adjustments.

The court in *Sacred Heart* stated that it was "the agency's practice . . . to modify a hospital's target amount, concern[ing] only changes that took place *during the hospital's base year.*" 958 F.2d at 548 (emphasis in original). Unfortunately, what the court did not understand is that all changes during a base year are incorporated into the TEFRA target amount. The new regulation was apparently intended to limit changes in the HSP to only those changes that began during the base year, which were not fully reflected in the base year costs.

The proposed rule was never promulgated as a final rule. Consequently, the limitations that would have been imposed by this "clarification" were never effective. Importantly, the proposed regulatory preclusion against a retroactive adjustment was specifically rejected in *Georgetown University Hospital v. Bowen,* 862 F.2d 323 (D.C. Cir. 1988). In addition, the purported principle against recognizing costs incurred after the base year was abandoned by the Secretary months later. (*See* App. 125a-131a.)

The third error by the *Sacred Heart* court, concerning statutory construction, was also made by the *Episcopal* court and is discussed below.

B. The District of Columbia Circuit's Opinion in *Episcopal*.

The decision of the Court of Appeals for the District of Columbia Circuit in *Episcopal* was similarly flawed. The court of appeals: (1) misapplied the two step analysis of *Chevron*; (2) failed to acknowledge or consider the conflict in the Third and Ninth Circuits on this fundamental issue of statutory construction; (3) failed to acknowledge or consider relevant and material legislative history; and (4) impermissibly deferred to the Secretary's litigation position, which was entitled to no deference under *Chevron* and *Good Samaritan*.

Petitioners submit that the errors in the *Episcopal* court's decision stem from the fact that the decision was based on an inadequate record. In the lower court, the parties in *Episcopal* assumed the application of the TEFRA Adjustments in the calculation of the HSP in light of the then unanimous court decisions on this issue. Consequently, the parties had no need to establish a complete legislative and regulatory record on this pivotal issue. Thus, the court was denied the opportunity to consider a complete record before rendering its decision.

The *Episcopal* court concluded that the target amount referred to in subparagraphs (d)(1)(A) and (b)(3)(A) are unaffected by the TEFRA Adjustments contained in subparagraph (b)(4)(A) *without*: (1) any discussion of the fact that subsection (*a*) was specifically *excluded* in subparagraph (d)(1)(A); (2) any references to the significant legislative history; (3) any reference to the other decisions addressing the issue; or (4) any reference to the significant regulatory history.

1. *The Episcopal Court's Rationale Under the First Step Analysis of Chevron.*

The court stated two points in support of its conclusion that the statute is unambiguous and that the TEFRA Adjustments plainly are not incorporated into PPS under a first step *Chevron* analysis. First, the Court noted:

> [S]ubsection (b)(4)(A) explicitly authorizes the Secretary to depart from the 'target amount' benchmark in (b)(3)(A) in specific circumstances, suggesting that incorporation of (b)(4)(A) might conflict with Congressional intent partially to base reimbursement on the target amount during the PPS transition period.

944 F.2d at 883.

The only provision of subparagraph (b)(4)(A) to which the court could be referring (since none is identified) concerns the assignment of a new base period which is more representative of the reasonable and necessary costs that a hospital incurs after its base year. What the court apparently did not recognize is that subparagraph (b)(4)(A) was amended to permit the assignment of a new base year by the Omnibus Budget Reconcilitation Act of 1989 §§ 6015(a) and (b), which became effective *after* the expiration of the transition period relevant to these appeals. Thus, the provisions of subparagraph (b)(4)(A) which caused the court concern were irrelevant to its analysis and conclusion.

The court also noted that Congress did provide for adjustments to PPS payments under 42 U.S.C. § 1395ww (d)(5)(I). 994 F.2d at 883.[14] The court indicated that incorporating the TEFRA Adjustments into PPS would be redundant given the adjustments in subparagraph (d)(5)(I). *Id.* What the court may have failed to understand (there is no explanation in the decision) was that the TEFRA Adjustments under subparagraph

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[14]This same argument was addressed in *Sacred Heart*, 958 F.2d at 546. For the same reasons discussed here, that analysis in *Sacred Heart* is as flawed as the conclusion in *Episcopal*.

(b)(4)(A) are mandatory while the adjustments under subparagraph (d)(5)(I) are permissive.[15]

Significantly, the court failed to recognize that the TEFRA Adjustments under subparagraph (b)(4)(A) are only applicable during the limited duration of the four year transition period, while the adjustments under subparagraph (d)(5)(I) are applicable for as long as PPS is in effect.

The *Episcopal* court's rationale also crumbles when one compares the congressional grant of authority to the Secretary under subparagraph (d)(5)(C)(i),[16] to adjust payments to regional and national referral centers, with the redundant grant of such authority under subparagraph (d)(5)(I). One must assume subparagraph (d)(5)(C)(i) is as redundant as subparagraph (b)(4)(A), but that Congress was not concerned with such redundancy. However, the *Episcopal* court failed to recognize this critical point in its flawed statutory analysis.

It is certainly true that the mere presence of the permissive adjustments under subparagraph (d)(5)(I) could raise an inference that Congress intended such a provision to be the exclusive adjustment process under PPS. However, such deductive reasoning is flawed under a first step *Chevron* analysis, where there is no legislative history to indicate such a preclusive purpose and there is legislative history, the provisions of subparagraph (d)(5)(C)(i), *and* the Secretary's official actions which support a contrary conclusion.

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[15] 42 U.S.C. § 1395ww(d)(5)(I) states: "The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate."

[16] 42 U.S.C. § 1395ww(d)(C)(i) states: "The Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection . . . as the Secretary deems appropriate to take into account the special needs of regional and national referral centers . . . ."

2. *Incorporation by Negative Inference.*

In *Chevron*, 467 U.S. at 842-43, this Court noted "[i]f the intent of Congress is clear, that is the end of the matter; for the Court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." The Court also stated "[t]he judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear Congressional intent." *Id.* at 843 n.9.

One tool which courts commonly use in statutory construction to determine congressional intent is the principle of incorporation by negative inference. This case provides a classic example which was ignored by the *Episcopal* court. In 42 U.S.C. § 1395ww(d)(1)(A), Congress expressly states that the PPS target amount is to be determined under Section 1395ww(b)(3)(A) but "without the application of subsections (a) of this section [Section 1395ww(a)]. . . ." The act of expressly excluding one subsection raises an inference that other subsections are not to be excluded. *See Andrus v. Glover Construction Company*, 446 U.S. 608, 617 (1980) ("[w]here Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied in the absence of a contrary legislative intent.").

Surely, if Congress had intended that the PPS target amount and resulting HSP portion be calculated "without application of subparagraph (b)(4)(A)," it would have stated such an exclusion as it did for subsection (a). Petitioners' conclusion is also supported by the legislative history which indicates that in an early version of the bill, Congress did specifically exclude some, but not these, TEFRA Adjustments and specifically, with respect to subsection 1395ww(b), excluded subparagraphs (b)(1)(A) and (B). *See* discussion *supra* at 12-13. At the very least, this history indicates Congress knew how to specifically exclude such adjustments and other provisions when intended. However, the *Episcopal* court ignored the express

wording of the statute and this compelling legislative history in reaching a flawed conclusion under *Chevron*.

III. TO CLARIFY THE APPROPRIATE STANDARD OF DEFERENCE TO AGENCY INTERPRETATIONS ESTABLISHED BY THE COURT IN *CHEVRON* AND IN *GOOD SAMARITAN*.

This case provides the Court with the opportunity to address the limits of judicial deference to agency conduct which an agency characterizes as a mistake, an issue addressed by the Court in *Good Samaritan Hospital v. Shalala*, —— U.S. ——, 113 S. Ct. 2151 (1993). Petitioners submit that the Third and District of Columbia Circuits' deferential standard significantly and unwarrantedly expands the standard set forth in *Chevron* and *Good Samaritan*.

In *Good Samaritan*, the Court acknowledged that the pertinent statutory language was ambiguous and considered the proper deference to be afforded to an agency's interpretation of a statute under the second step of *Chevron*. *Good Samaritan*, 113 S. Ct. at 2159. The hospitals there argued that deference to the agency's position was unwarranted in light of its shifting views over the years. *Id.* at 2160.

The Secretary argued that her shifting positions were attributable to the "lower courts' erroneous interpretations" of the statute and that "in the aftermath of *Georgetown* [488 U.S. 204 (1988)], she notes the agency returned to its earlier position." *Id.* Thus, the Secretary argued that her positions were not inconsistent and warranted deference by the Court.

This Court acknowledged that the Secretary is not estopped from changing a view that she believes to have been grounded upon a mistaken legal interpretation. *Good Samaritan*, 113 S. Ct. at 2161. However, the Court also noted that:

> On the other hand, the consistency of an agency's position is a factor in assessing the weight that position is due. As we have stated, "[a]n agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held view." . . . How much weight should be given to the agency's views in such a situation, and in particular where its shifts might have resulted from intervening and possibly erroneous judicial decisions and its current position from one of our own rulings will depend on the facts of individual cases.

Id. Thus, the standard set forth by this Court in *Good Samaritan* is not a departure from, but rather a reaffirmation of, previously enunciated principles of judicial deference.

In *Sacred Heart* and *Episcopal,* the courts relied upon the first and second step analyses of *Chevron* to hold that subparagraph (b)(4)(A) was inapplicable to the HSP calculation. *Sacred Heart,* 958 F.2d at 547-48; *Episcopal,* 994 F.2d at 883-84. It is this second step analysis which runs afoul of this Court's holding in *Good Samaritan.* The problem with both decisions is that neither the courts nor the Secretary identified the "reasonable interpretation" of the Secretary to which the court must defer.

There is no "official" interpretation of the Secretary other than the Secretary's litigation position which states that subparagraph (b)(4)(A) is inapplicable to the calculation of the HSP. To the contrary, the Secretary in her official actions has granted the same TEFRA Adjustments which Petitioners sought. Further, the Secretary has never stated that she corrected—*i.e.,* reversed—the TEFRA Adjustments that she had granted to other hospitals based on her newer interpretation that such adjustments were unlawful.

As noted above, when the Secretary adopted regulations implementing PPS, she stated in the preamble to the final PPS regulations that:

> We believe that Congress intended to assure, by giving us broad authority under the law to provide for exceptions, exclusions and adjustments, that some hospitals are not advantaged or disadvantaged by unique circumstances in their base year that do not reflect their usual cost of operation per case. *This intent is indicated in Section 1886(b)(4)(A) [subparagraph (b)(4)(A)] of the Act.*

49 Fed. Reg. at 261 (January 3, 1984) (emphasis added). Thus, at the outset of PPS, the Secretary advised hospitals that the TEFRA Adjustments under subparagraph (b)(4)(A) would be available to calculate the HSP.

Within a year of the Secretary's statement in the Federal Register, the Secretary granted such TEFRA Adjustments under subparagraph (b)(4)(A) to hospitals for PPS purposes. Correspondence preceding the litigation in *Greenville* clearly supports this proposition. *Greenville,* 642 F. Supp. 15 (D.S.C. 1985) (concerning jurisdiction), *after remand,* Medicare and Medicaid Guide (CCH) ¶ 35,880 (D.S.C. 1986) (granting retrospective relief for an HSP adjusted by the Secretary under subparagraph (b)(4)(A)). Greenville sought a TEFRA Adjustment so that its target amount and HSPs reflected the reorganization of its two hospitals. Greenville's intermediary calculated its HSP "based on each hospital's base year costs, without consideration of the significant changes that had occurred after the base year." 642 F. Supp. at 17.

After discussions between counsel for Greenville and HCFA personnel, the Administrator of HCFA, Carolyne K. Davis, agreed it was appropriate to adjust Greenville's base year costs under 42 C.F.R. § 405.463(h) (*recodified as* § 413.40(h)), resulting in a different target amount and authorized the *prospective* use of that different target amount to develop a revised HSP for each hospital pursuant to 42 C.F.R. § 412.72.[17] *See* May 2, 1984 letter from Carolyne Davis to Leonard Homer. (App. 119a.)

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[17] 42 C.F.R. § 405.463(h), *recodified as* § 413.40(h), embodies the regulatory exceptions, adjustments and exemptions that modify the

HCFA's rationale in applying the TEFRA Adjustments to these PPS hospitals could not have been stated more clearly:

> We have . . . decided to treat your request as an application for an adjustment to GHC's cost per case for the cost reporting period subject to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), as authorized by regulation 405.463(h) [*recodified as* 413.40(h)]. Under that regulation, HCFA may adjust operating costs considered in establishing a hospital's TEFRA-year cost per case to *take into account factors which could result in a significant distortion in the operating costs of inpatient hospital services.* Because of the substantial magnitude of the costs affected by the Greenville realignment, we have determined that a significant distortion in GHC's operating costs would exist without an adjustment, and *we are therefore, granting the adjustment* described below [for PPS purposes].
>
> As you know, the amount of the hospital-specific portion (HSP) of PPS payment is determined by reference to each hospital's target amount under TEFRA. The adjustment to GHC's TEFRA-year costs granted by this letter will therefore result in increased HSP payments to GHC, effective from cost reporting periods beginning after the date of this letter.

Id. (emphasis added).

Subsequent to the Greenville determination, the Secretary issued a *proposed rule* at 51 Fed. Reg. 8208 (March 10, 1986). (App. 105a.) The proposed rulemaking states as its purpose that it:

> [W]ould clarify Medicare's policy regarding changes to the hospital-specific portion of the prospective payment rate for inpatient hospital services. We would clarify that exemptions, exceptions, and adjustments to base year costs permitted under the Medicare cost

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TEFRA target rate, which is also the target rate under PPS. This regulation was adopted under 42 U.S.C. § 1395ww(b)(4)(A).

> limits and rate-of-increase ceiling authority *will* affect the hospital-specific portion of the prospective payment rate.

51 Fed. Reg. 8208 (March 10, 1986) (emphasis added). The proposed rulemaking was *not* a change in previous erroneous policy, but was a "clarification" of existing policy. Thus, any contention by the Secretary that the TEFRA Adjustment under subparagraph (b)(4)(A) is not available to modify the HSP rate is simply inconsistent with the existing policy which the Secretary sought to clarify on March 10, 1986.

The March 10, 1986 proposed rule would have "clarified" existing HCFA policy by placing limitations on when costs must begin to be incurred (*i.e.*, not after the base year) and by prohibiting retroactive adjustments. However, HCFA continued to rely on the TEFRA regulations, 42 C.F.R. § 405.460 (*recodified as* § 413.30), and 42 U.S.C. § 1395ww(b)(4)(A) as the authority for such adjustments. In addition, the Secretary declined to adopt additional adjustments under 42 U.S.C. § 1395ww(d)(5)(C)(iii) (sic). (App. 115a.)

As noted above, the proposed rule was never promulgated as a final rule. Consequently, the limitations that would have been imposed by this "clarification" on the application of subparagraph (b)(4)(A) to the HSP calculation were never given the force and effect of law.

Second, and apparently not known to the Third Circuit when it rendered its decision in *Sacred Heart* and not discussed by the court in *Episcopal,* HCFA again determined that TEFRA Adjustments under subparagraph (b)(4)(A) continued to be available to revise a hospital's target amount and HSP to recognize extraordinary costs incurred *after* its base year. This "official" action is memorialized in correspondence dated April 24, 1986 and May 14, 1986, from Linda Magno, Director of HCFA's Division of Hospital Payment Policy, a few short months after publication of the proposed clarifying rule and directly contrary to that clarification's prohibiiton

against considering additional costs incurred after the base year. (App. 125a-131a.)

These agency actions are the only "official" actions on this issue. The Secretary's litigation position in *Sacred Heart* and *Episcopal* constitutes nothing more than the *post hoc* rationalization of counsel, which this Court in *Motor Vehicle Manufacturers Association v. State Farm Mutual Automobile Insurance Co.*, 463 U.S. 29 (1983), appropriately noted is entitled to *no deference at all.*

Unlike *Good Samaritan,* the Secretary never claims that she was required to adopt a mistaken interpretation of a statute as the result of an erroneous court decision. She merely changed her position concerning the proper interpretation of the statute and claimed that her prior interpretations were incorrect.

Thus, the court of appeals' decisions in *Episcopal* and *Sacred Heart* to defer to the Secretary's interpretation of the underlying statute were clearly flawed and were inconsistent with the standards set forth by this Court in both *Chevron* and *Good Samaritan.*

The opinion recently issued by the United States District Court for the Middle District of Florida in *Hillsborough* is even more egregious. There, the court held that the Secretary is entitled to deference, under *Good Samaritan,* if the Secretary's position is "reasonable." *Hillsborough,* Medicare and Medicaid Guide (CCH) ¶ 41,979 at 38,548. The court cites *Good Samaritan* for the proposition that the Secretary is not estopped from changing a view that she believes to have been grounded upon a mistaken legal interpretation. *Id.* However, the court completely disregards the second prong of this Court's statement in *Good Samaritan* concerning the lower level of deference to be accorded to such changing interpretations.[18]

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[18] Notably, government counsel made the same argument to this Court in its Brief for the Respondent in Opposition in *Episcopal Hospital, et al. v. Sullivan,* No. 93-429, at p. 13 n. 7.

Accordingly, Petitioners urge this Court to grant a writ of certiorari in this case and clarify its position regarding the proper judicial deference to be accorded a changing agency position which is based on a finding by the agency that it was mistaken in its initial interpretation.

CONCLUSION

For the foregoing reasons, Petitioners respectfully request the Court to grant the Petition and issue a writ of certiorari to the United States Court of Appeals for the District of Columbia Circuit.

Respectfully submitted,

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